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All-Payor Medical-Home Pilot Begins In R.I.

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By Ric Gross

Three major health insurers in Rhode Island have joined with the state and five physician practices to launch a statewide, all-payor medical home pilot initiative.

The state's largest insurer, Blue Cross & Blue Shield of Rhode Island, joins with UnitedHealthcare of New England, Neighborhood Health Plan and the state's Medicaid program in what is known as the Rhode Island Chronic Care Sustainability Initiative, which launched Oct. 1.

The two-year pilot seeks to align patient care improvement goals and financial incentives among the state's medical providers, purchasers and health plans, supported by the Office of the Health Insurance Commissioner and Quality Partners of Rhode Island.

A variety of medical home pilots are under way across the nation, run by individual health plans. For example, partnering with WellStar Health System, Humana has launched a pilot program for a medical home model in Atlanta, with additional pilots set for Kentucky, Chicago and south Florida.

In New Hampshire, CIGNA HealthCare and Dartmouth-Hitchcock Medical Center have teamed to launch a new patient-centered medical home pilot program focused on CIGNA members who receive care from Dartmouth-Hitchcock primary-care physicians practicing in family medicine, internal medicine and pediatrics.

However, what sets Rhode Island apart is having the state's three major health plans on board.

"All-payor projects are the Holy Grail," said Christopher Koller, Rhode Island's health insurance commissioner. "Medicare can have a well-designed program, a commercial health insurer can have one, but if they are not designed in the same way, it makes it hard for the target—the physician—to really act in concert with what's being asked of them. We set out with the understanding all payor was important," Koller said.

Gus Manocchia, M.D., chief medical officer for BC/BS of Rhode Island, said the project is in a unique position to succeed. "Right now we are the one unique demonstration with this many payors involved," he said. "It is really good for the practices. They don't have to say, 'OK, because you are a BC/BS patient I will treat you this way, and because you are with this other carrier I will treat you this way.' There has been quite a bit of collaboration on this project among both the payors and the physicians involved, and there certainly will need to be more as the project moves forward."

What Is A Medical Home? The American College of Physicians describes a medical home as a team-based model of care led by a personal physician who provides continuous and coordinated care throughout a patient's lifetime. This care includes preventive services, as well as coordinated treatment of acute and chronic illness.

The medical home is meant "to address the fragmented, uncoordinated episodic care that many Americans receive," according to the 2007 annual report of the National Committee for Quality Assurance. "With an estimated 150 million Americans predicted to be living with at least one chronic illness by 2015, the importance of comprehensive care management cannot be underestimated."

The Rhode Island initiative, created with seed funding from the Center for Health Care Strategies, will include five physician practices that will receive additional payment for coordinating and delivering high-quality care related to coronary artery disease, diabetes and depression. Each of the five practices will treat patients by utilizing patient-centered medial home programs that meet NCQA and Physician Practice Connections-Patient Centered Medical Home standards.

In total, the five practice sites care for a combined 25,000 patients who will be taking part in the pilot. The sites are Coastal Medical, Family Health & Sports Medicine Foundation, Hillside Avenue Family and Community Medicine, Thun-

THE 11 REQUIREMENTS FOR A PATIENT CENTERED MEDICAL HOME

1. A personal medical home
2. Patient-centered care
3. Team approach to care
4. Elimination of scheduling and communication barriers
5. Advanced, data-based information systems, including electronic health records
6. Redesigned and more functional offices
7. Integrated and whole-person orientation
8. Care provided within a community context
9. Focus on quality and safety
10. Sustainable reimbursement and profitable practices
11. Commitment to provide a consistent set of services

Source: Robert Jackson, M.D., Medical Advantage Group

ESTIMATED BENEFITS FROM PCMH MODEL

Savings on inpatient and physician reimbursement	30%
Reduction in hospital admissions	10%
Reduction in ER visits	20%
Reduction in absenteeism	10%

Source: Deloitte Center for Health Solutions, "The Medical Home: Disruptive Innovation for a New Primary Care Model"

dermist Health Center and University Medicine Foundation.

"One of the real challenges was defining the patients that were assigned to the primary-care site," Koller said. "We spent four to six months reconciling health plan numbers to the doctor's numbers. There were a number of differences, and it came down to the PPO model that allows people to bounce all over the place. The other was the short-term nature of health insurance. People cycle on and off."

Health plans will be providing funding to allow nurse case managers to operate on site, as well as a monthly $3 per-member, per-month fee to each practice for enhanced services. According to the Health Commissioner Office's modeling, BC/BS's PMPM payment would equal $554,544, representing 15,404 members; UnitedHealthcare, $208,764, representing 5,799 patients; and Neighborhood Health Plan, $122,364 representing 3,399 patients. Additional funds will be contributed by the insurers for the nurse case managers, with larger practices getting more on-site nurses. Medicaid is integrating an existing primary-care case management model, including nurse care managers and supplemental funding.

The Harvard School of Public Health will be evaluating how successful the practices are in aligning with the primary-care medical home concepts, as well as determining the return on investment.

"We think we will learn a lot from this," Manocchia said. "Not only in terms of hopefully seeing improvement in the patient experience of care, but we think the advanced medical home concept is really pivotal in potentially reviving primary care and primary-care practices in general, which right now are withering on the vine."